# OCCUPATIONAL THERAPY INITIAL ASSESSMENT

UR No: ……..

Name: ……..

DOB: ……..

***Affix Patient Identification Label here.***

**Admission Date:** ….. / ….. / …… **Contact Date:** ….. / ….. / …… **Therapist:** ……..……

| **DIAGNOSIS:** | **MEDICAL HISTORY:** |
|---|---|
| | |
| | |
| | |
| | |

**SOCIAL SITUATION:** ……
……
……

**OCCUPATIONAL PERFORMANCE AREAS:**

**Key: I = independent A = Assistance required D = Dependent**

| | | **Previous Status** | | **Current Status** |
|---|---|---|---|---|
| **Mobility** | | | | |
| Bed Mobility | | | | |
| Transfers | | | | |
| Mobility / Balance | | | | |
| **Personal care ADL** | | | | |
| Eating | | | | |
| Grooming | | | | |
| Dressing | | | | |
| Bathing | | | | |
| Toileting | | | | |
| Self Medication | | | | |
| **Domestic ADL** | | | | |
| Meal Preparation | | | | |
| Housework | | | | |
| Laundry | | | | |
| Garden / Home Maintenance | | | | |
| **Community ADL** | | | | |
| Driving / Transport | | | | |
| Financial Management | | | | |
| Shopping | | | | |
| Writing / Telephone | | | | |

**Work:** ……

**Leisure:** ……

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| PERFORMANCE COMPONENTS |
|---|
| **BIOMECHANICAL:** |
| **SENSORY MOTOR:** |
| **COGNITION / BEHAVIOUR:** |
| **VISION / PERCEPTION:** |
| **PSYCHOSOCIAL:** |

| ENVIRONMENT: HOME SETUP | | | | | |
|---|---|---|---|---|---|
| **Type:** | ❑ House | ❑ Unit | ❑ Hostel | ❑ Nursing Home | ❑ Other:…….. |
| **Ownership:** | ❑ Owned | ❑ Rented | ❑ Government | ❑ Boarding | ❑ Other:…….. |
| **Personal Alarm:** | ❑ Yes | ❑ No | Company:…… | | |

| | |
|---|---|
| Front Access: | |
| Back Access: | |
| Internal: | |
| Bathroom: | |
| Toilet: | |
| Bedroom: | |
| Seating: | |
| Other: | |

| ISSUES IDENTIFIED | GOALS / PLAN |
|---|---|
| | |
| | |
| | |
| | |
| | |

**Therapist Name:**…….. **Therapist Signature:**…… **Date:** ……. / ……. / …….